The recent study by Taft and colleagues, which explores communication differences in paper versus electronic health records (EHRs), was both interesting and timely. EHRs are becoming a focal point for healthcare delivery in the US, yet the impact of EHRs on the patient-provider relationship remains poorly understood. Communication is at the heart of this relationship, and providers are concerned about the potential for EHRs to reduce the quality of their communications with patients.

We would like to provide additional thoughts on Taft et al.’s reported findings and put them into a broader context. First, it is interesting to note that the authors found that EHRs fostered better communications with patients across nearly all measures. However, we wonder what might explain why a physician would greet a patient more warmly when walking into an exam room with a laptop computer vs. a paper chart. This suggests that the effect of EHRs vs. paper records must either be very strong and rapid or that there may be other factors at play.

With regards to the overall premise of comparing paper to electronic charts – EHRs are capable of much more than paper records, but that capability is partly the reason why clinicians may perceive that patient communications have been impaired by EHRs. Clinicians in the exam room are taking on more tasks and interacting with the EHR in ways that were not possible with paper records. For example, tasks associated with an ambulatory EHR that do not have comparable actions in paper records include acknowledgment of medical assistant- or nurse-entered data via button clicks; e-prescribing, which enforces more conformity than paper prescriptions and may display numerous alerts that require review and confirmation; coding the encounter for billing purposes, which might previously have been handled by clerical staff; responding to reminders about immunizations and overdue tests (and subsequent order entry); documenting the encounter using dropdown menus, checkboxes, free-text entry, and many other modalities; and other documentation requirements that have resulted from new healthcare regulations, such as meaningful use.

The Methods section of the Taft et al. article stated that their mock EHR was “styled after the Department of Veterans’ Affairs’ computerized patient record system,” but it is unclear how many of the aforementioned tasks were handled by the residents using the system in the study or even if the study’s mock EHR supported these complex functions. Practicing clinicians will readily recognize the challenges of handling these tasks, especially entering data through structured data entry forms and responding to computer-generated alerts, while interacting with patients. These additional tasks are not necessarily bad, and some only exist because EHRs enable them and because they are considered beneficial (eg, drug safety alerts), but they do present different challenges than paper records. Clinicians are certainly not required to perform all of the tasks required by the EHR while the patient is in the exam room, but time pressures often encourage them to do so. In summary, if residents in the Taft et al. experiment did not complete many of these additional tasks while interacting with patients, then the study scenarios may not represent realistic and typical EHR use.

Further, while the authors clearly took great care to reduce potential biases, including not informing the residents or patient actors about the purpose of the study, it is not clear if the raters were also blinded to the study’s objectives. It would be interesting to see if the measures of residents’ communication skills would change if the raters were only provided with audio recordings of the physician-patient interactions, without the accompanying video footage. Furthermore, in this context, patients’ perceptions may be more relevant. While patient actors in the study were given a copy of the communication tool “so they could provide feedback to the residents’ supervisors at the end of the study,” their impressions about the residents’ communication skills were not reported.

We look forward to future work on how EHR use impacts physician-patient communications, including comparisons of experienced clinicians using different EHRs in real practice settings. Some studies have noted communication differences between providers who engage in extensive in-room EHR use and those who use the EHR minimally during patient encounters. There is no standard etiquette about what does or does not constitute appropriate EHR use during an ambulatory encounter.
patient encounter, but further study of EHR use and doctor-patient communication could help inform better EHR usage guidelines.

REFERENCES


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